

# **North Carolina Quality Assessment and Improvement Strategies October 5, 2004 Status Report**

## **I. Process for Quality strategy development, review, and revision**

### **A. BBA-compliant Contract Amendments**

- The HMO contract was finalized August, 2003 to include the following BBA-compliant amendments:
  1. The Plan must have an overall quality improvement program that is integrated into the Plan's activities and involves key decision-making staff.
  2. The Plan must submit annual reporting to include a patient and provider satisfaction survey annually, HEDIS data and DMA measures regarding utilization and Plan performance, quarterly complaint and grievances reports, and data for CSHCN.

**\*Please see the HMO Contract at**

**[Http://www.dhhs.state.nc.us/dma/mco/Finalmco.pdf](http://www.dhhs.state.nc.us/dma/mco/Finalmco.pdf)**

- The Plan is required to develop and implement a minimum of two performance improvement projects that focus on clinical and non-clinical areas the first year, three projects in year two and four projects in year three of the contract.
  1. The Plan submitted performance improvement project plans for 4 clinical projects: improving breast cancer screening rates, improving lead screening rates, improving adolescent immunization rates, and improving health check screening rates. The results of these projects will be reported by June, 30, 2005 when the Plan reports their annual data to the State.
  2. The Plan submitted a non-clinical performance improvement project for improving provider satisfaction. Results will be reported by June 30, 2005.

**\*Please see the HMO contract at**

**[Http://www.dhhs.state.nc.us/dma/mc/Finalmco.pdf](http://www.dhhs.state.nc.us/dma/mc/Finalmco.pdf)**

- The State amended the current Medical Review of North Carolina, Inc. (MRNC) contract to include the external quality review (EQR) requirements as outlined in the BBA. The EQR was completed by MRNC for two of the three mandatory activities: validation of performance measures and validation of performance improvement projects using CMS protocols. The third mandatory activity, monitoring Medicaid managed care organizations and prepaid inpatient health Plans, will be completed by the DMA Managed Care Staff following the

CMS protocol. Results of this activity will be audited by the EQR contractor in 2005.

- The State also will issue a request for proposal for EQRO contracting effective January 1, 2005. The request for proposal is currently in the DMA Purchasing and Contracts section for review and approval prior to issuance.

**\*Please see Attachment I- Amendment to Medical Review of North Carolina, Inc. Contract and RFP entitled “External Quality Reviews for Managed Care Systems and HMO which can be viewed at**

**<http://www.ips.state.nc.us/ips/AGENCY/PDF/03931100.pdf>**

- B. The annual review of this quality strategy occurred in fourth quarter of 2004 by review of the information contained in the strategy and review of the enclosed attachments. No changes were made in the strategy for 2005. The State plans to reevaluate and revise (as necessary) the strategy in the fourth quarter of each calendar year.
- C. After review of this strategy, reporting data, and complaint data, the State’s Quality Management and Program Operations staff determined there was not a significant change to warrant a stake holder’s meeting for calendar year 2004.
- D. The State has reviewed the quality strategy for 2004 and will revise the strategy as needed during 2005.

## **II. Managed Care Program Goals and Objectives**

The State has held HMO Plan Mobilization Meetings quarterly in Mecklenburg County. Representatives from the DSS, Plan, enrollment broker and the Division attend these meetings to assess the quality and accessibility of services to HMO enrollees. Additionally, the Division’s Managed Care Quality Management section meets quarterly with the QM/UM representatives of the Plan and the DSS discuss quality initiatives and progress toward goals.

**See Attachment II-Sample of Agenda and Minutes for Quarterly QM Meetings and Plan Mobilization Meetings.**

## **III. Medicaid Contract Provisions**

Contract provisions regarding access to care, accessibility of services, appointment availability and wait times, choice of a health professional, emergency services, structure and operations, or quality measurement and assessment have not been changed except for Sections 1.7, 2.2, 2.3, and Appendix IX, Grievance Procedures, Section C (except for the last two paragraphs). These sections were amended in April, 2004 to comply with BBA requirements.

#### **IV. State Standards for Access to Care**

State standards for access to care are covered in the MCO contract sections 6.2, 6.3, 6.4, 6.5, 6.6, 6.8, 6.14, 6.36, 7.6 and Appendix XV (attached). There has been no change with the MCO contract or state standards for access to care since the original strategy was submitted to CMS. These sections of the contract include provisions for Children with Special Health Care Needs (CSHCN) who elect to enroll with the MCO to utilize specialists as PCPs and be evaluated for case management services by the MCO. Enrollment with the MCO for CSHCN is voluntary.

#### **V. State Standards for Structure and Operations**

There have been no changes to the MCO contract regarding structure and operations of the MCO since the original strategy was submitted to CMS. Structure and operations requirements are listed in sections 4.1-4.9, 6.11, 7.5, 7.6, 7.7, 8.2, 12.1, Appendix V and Appendix IX (amended).

#### **VI. State Standards for Quality Measurement and Improvement**

1. Practice guideline requirements were assessed as part of the mandatory external quality review. Policy and procedures adopted by the Plan to develop appropriate practice parameters are compliant with Section 7.1 of the MCO contract.
2. The quality assessment and performance improvement program is included in Section 7.1 and Appendix XVII of the MCO contract.
3. The contract states in Appendix V the statistical reporting requirements for the Plan due by June 30 of each calendar year of the contract. The reporting includes HEDIS measures, CAHPS survey for children and adults, and measures developed by the Division to assess Plan performance. The annual reports are reviewed by Division Managed Care QM staff. Based on analysis of the results, the MCO may be required to submit a corrective action plan to the Division.
4. Health Information systems requirements are found in section 7.8 of the MCO contract. Utilization, provider and enrollee characteristics as specified by the Division are reported with the annual statistical report. Complaint, grievance and appeal data is submitted by the Plan to the Division on a quarterly basis. Involuntary disenrollments must be approved in advance by the Division after careful review of supporting information.
5. As previously mentioned, CSHCN are not mandated to enroll in the MCO. For CSHCN enrollees choosing the MCO, the State requires the MCO to contact, assist the enrollee in choosing a PCP, assess for case management needs, assign a case manager and report subsets of statistical data for CSHCN in a timely manner. The State requirements are covered in Section 6.14 and Appendix V of the MCO contract.

**\*Please see the HMO contract at**

## **VI. State Monitoring and Evaluation**

The State reviews the data submitted by the MCO and provides feedback to the Plan in Quarterly QM meetings and by written communication. The State works collaboratively with the Plan to determine topics for Performance Improvement Projects for the following year based on a comparison of State and Plan-generated HEDIS measures. The State conducted an onsite visit to the Plan on November 1, 2004 and conducted formalized telephonic interviews on December 1, 2004 to assess compliance with the contractual requirements and to complete the EQR activity, "Compliance with Managed Care Regulations".

### **A. Arrangements for External Quality Reviews**

1. In order to comply with BBA requirements, the State amended the current contract with Medical Review of North Carolina, Inc. to include the external quality review requirements outlined in the BBA for "Performance Improvement Projects" and "Performance Measures". The external quality review for these activities was completed in 3rd quarter with the final report delivered to the State in 4<sup>th</sup> quarter, 2004. The MCO has been requested to submit to the State a detailed corrective action for all deficiencies noted no later than January 31, 2005.
2. The State conducted the 3<sup>rd</sup> mandatory activity, compliance with managed care regulations with permission from CMS and will have the findings and report assessed by the EQRO in 2005.
3. The RFP for the 2005 external quality review is scheduled to be published no later January 1, 2005, although due to requirements of the State's contracts section, may be delayed to later in the 1<sup>st</sup> quarter of 2005. The EQR will occur in 2<sup>nd</sup> and 3<sup>rd</sup> quarter with a final report due 4<sup>th</sup> quarter of 2005.
4. The report will be used to evaluate the effectiveness of the State's quality strategy and the strategy will be amended as needed for the following calendar year.

## **VII. Procedures for race, ethnicity and primary language.**

- A. The State plans to identify the race, ethnicity and primary language of each Medicaid MCO enrollee at the time of application at the DSS. The caseworker will enter the data into the Eligibility Information System (EIS) as instructed by the State. This information will be downloaded into

the MMIS+ and DRIVE data systems and will be placed on the monthly MCO enrollment report.

- B. The SSI population is a difficult and costly one for the State to reach effectively. Even race is often not reported by SSA to us on SSI recipients. Our plan is to code race into our EIS as unreported when SSA sends us “unknown” as the race indication.

The State does not have the financial or personnel resources available to collect this information at this time, but will explore options to address the issue.

#### **VIII. National Performance Measures and Level**

The State plans to incorporate performance benchmarks for the MCO to be included in the next contract issue. The benchmarks will be based on the NCQA HEDIS performance benchmarks for selected HEDIS measures, the MCO’s self-reported data on specific State measures, and the benchmarks contained in the present contract.

The State Plans to assess financial withholds on the plan when specific benchmarks are not met.

#### **IX. Intermediate Sanctions**

The State describes the use of intermediate sanctions in support of its quality strategy in section 14.5 of the MCO contract.

**ATTACHMENT I**

**AMENDMENT TO THE MEDICAL REVIEW OF  
NORTH CAROLINA CONTRACT**

**MANAGED CARE QUALITY REVIEWS CONTRACT**

**RFP # DMA-148-02 - P&C # 200292**  
**AMENDMENT NO. 3**

NOW COME Medical Review of North Carolina, Inc. (hereinafter the "Contractor") and the Division of Medical Assistance (hereinafter the "Division") in the North Carolina Department of Health and Human Services and hereby amend the above-referenced 1 July 2001 contract (hereinafter the "Contract") for the reasons, and in the manner, described below.

WHEREAS, the Centers for Medicare and Medicaid Services (CMS) amended Parts 433 and 438 of Title 42 of the Code of Federal Regulations on January 24, 2003;

WHEREAS, the amended rules require that the Division's Quality Management (QM) program provide for external quality review of the Managed Care Organization (MCO) currently providing services to Medicaid recipients in Mecklenburg County;

WHEREAS, the activities mandated by CMS include: 1) Validation of Performance Measures and 2) Validation of Performance Improvement Projects; and

WHEREAS, the Contractor and the Division have each concluded that the Contract must be amended for the Division to maintain compliance with the above-cited changes in the CFR;

NOW THEREFORE, the Contract is amended as follows:

- I. The Contract Section captioned "Responsibilities of the Contractor" is amended to read as follows:

The Contractor shall:

- A. Develop and implement a focused care study of the Children with Special Health Care Needs with approval and oversight by the Division as follows:
  1. Develop the study design with the approval and oversight of the Division.
  2. Design and Pilot Test the Abstraction Tool to include:
    - a. Research and abstract information from target group medical records.
    - b. Validate the Abstraction tool to ensure that the information gathered from the medical record accurately reflects the medical record documentation.
    - c. Revise the abstraction tool as required by pilot testing results.
    - d. Request approval from the Division of the abstraction tool prior to proceeding with the full study.
    - e. Prepare an abstraction pilot progress report, including date of onsite visit, duration of onsite visit, number of charts reviewed, and whether provider agreed to allow use of de-identified records for abstractor training.
  3. Complete 1800 medical record reviews and abstractions, in two groups of 900 each, using the approved medical record abstraction tool. Create and deliver an abstract of each record reviewed and a summary report that details the number of records reviewed and abstracted, the number of provider sites visited and number of sites/abstractions to be completed.

4. Deliver all record abstracts and reports to the Division (on CD or diskette) prior to final payment. The Division shall retain ownership of all data and reports.
- B. Conduct External Quality Reviews (EQR) pursuant to the requirements of 42 CFR 438, Subpart E, "External Quality Review of Medicaid Managed Care Organizations". Activities include:
1. Examine and validate plan performance data required in the HMO contract with DMA for annual statistical reporting.
  2. Examine and validate performance improvement projects developed by the State Plan.
- These activities will be accomplished through review and analysis of the HMO's performance improvement projects and performance measures following the federally approved CMS protocols.
- C. Submit a Final Report to DMA/QM unit of the Contractor's findings no later than 90 days after the external review activities are completed and prior to the end of the contract term of October 31, 2004. The EQR report must include the following (as outlined in 42 C.F.R. 438.364):
1. A detailed technical report explaining how data were aggregated and analyzed and conclusions drawn as to the quality, timeliness, and access to the care furnished by the HMO to include objectives, technical methods of collections and analysis, description of data, and conclusions drawn from the data.
  2. An assessment of the strengths and weaknesses of the HMO.
  3. Recommendations for improving the quality of care by the HMO.
  4. An assessment of the degree to which the HMO effectively addressed the recommendations for quality improvement made during the previous year's quality review based on performance measures transmitted from the Division.
- D. Perform the following mandatory activities using CMS protocols (as defined in 42 C.F.R. 438.360):
1. Validation of performance improvement projects.
  2. Validation of HMO performance measures.
- E. Provide qualified personnel including:
1. A designated project manager responsible for the oversight of the activities contained in the contract amendment who will function as a contract/liaison with DMA.
  2. An experienced and trained registered nurse or licensed practical nurse under the supervision of a registered nurse, to perform the medical record reviews.

3. Provide the sufficient expertise in research methodology and statistical analysis required to undertake this activity.
- F. Provide staff which have demonstrated experience and knowledge, as defined in 42 C.F.R. 438.354(b), of:
1. Medicaid recipients, policies, data systems and processes.
  2. Managed care delivery systems, organizations, and financing.
  3. Quality assessment and improvement methods.
  4. Research design and methodology, including statistical analysis.
- G. Assure confidentiality of information obtained through these activities as required by federal and state laws.
- H. Retain medical records for a period of three years for potential audits by DMA or CMS as permitted under Section 1902(a)(30)(C) of the Social Security Act.
- I. Notify the Division immediately when a flagrant quality of care issue is observed or noted during any part of the review.
- J. Participate in quarterly Quality Improvement meetings and other DMA-sponsored meetings upon invitation by DMA.
- K. Attest and affirm, through signature of this Amendment, understanding and compliance with restrictions defined in 42 C.F.R. 438.354(c):

The Contractor shall not review a particular HMO if either the Contractor or the HMO exerts control (defined in 48 CFR 19.101) over the other through:

1. Stock ownership
2. Stock options and convertible debentures
3. Voting trusts
4. Common management, including interlocking management
5. Contractual relationships in which they:
  - a. Deliver any health care services to Medicaid recipients
  - b. Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of HMO services, except for EQR-related activities
  - c. Have a present, or known future, direct or indirect financial relationship with an HMO that it will review as a Contractor.

Financial relationship means a direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes

any indirect ownership or investment interest no matter how many levels removed from a direct interest; or a compensation arrangement with an entity.

II. The Contract Section captioned "Responsibilities of the Division" is amended to read as follows:

The Division shall:

- A. Furnish the Contractor the CMS required protocols for the external review activities contained in this amendment.
- B. Review and make any final determinations regarding the content, structure, and format including audit tools, review criteria, and any other materials to be used by the Contractor for the review.
- C. Participate with the Contractor in briefings regarding procedures, protocols, criteria and standards to be used in the validation process.
- D. Conduct monitoring and evaluation of the activities defined in this amendment.
- E. Provide consultation and technical assistance in the development of the reviews and other activities as needed.
- F. Respond to written inquires submitted by the Contractor within ten (10) business days of receipt.
- G. Furnish to the Contractor the HMO performance measures as included in Appendix V of the HMO contract, no later that five (5) business days from receipt from the HMO. These are due to the Division no later than June 30<sup>th</sup> each year.

III. The Contract Section Captioned "Payment for Services" is amended to read as follows:

No additional funding shall be added to this Contract. The total Contract cost shall not exceed \$445,524.00. All remaining payments for all remaining deliverables shall be made net 30 days by the Division upon delivery by the Contractor and written acceptance by the Division according to the following schedule:

Contract Tasks	Contract Deliverables	Quantity	Amount / Frequency	Reimbursement Totals
<b>Quality Studies:</b>				
Development of studies for Division Approval	Attendance at all meetings and submission of all monthly reports.	6 monthly upon acceptance by the Division		
Complete abstraction tool pilot and pilot is approved by the Division	Monthly Progress reports containing date of onsite visit, length of time of visitation, number of charts reviewed, changes or editing required to the pilot as a result of the testing & whether provider agreed to allow use of de-identified records for abstractor training.	6 – monthly upon acceptance by the Division		
Upon completion of	Status report at completion of	1	Upon	

900 chart reviews	900 medical record review that details number of abstracts completed, number of sites completed & number of sites/abstracts left to be completed and submission of chart data on CD or diskette number of sites/abstracts remaining to be completed.		Completion and Acceptance by the Division	
Upon completion of 1800 chart reviews	Status report at completion of the second 900 medical record review that details number of abstractions completed, number of sites completed and submission of chart data on CD or diskette.	1	Upon Completion and Acceptance by the Division	
Upon chart abstraction data submission and acceptance by DMA	Chart abstraction data downloaded (CD or diskette) and delivered to the Division. This shall include individual chart and a tabular compilation of data.	1	Upon Delivery and Acceptance by the Division	
<b>EQRO:</b>				
Validation of Performance Improvement Projects using CMS protocols and worksheets. (42 CFR Section 438.358(b)(1)- Validation of performance improvement projects required by the State to comply with requirements set forth in Section 438.240(b)(1) and that were underway during the preceding 12 months.)	Completion of "Validation of Performance Improvement Projects" protocol, Version 1.0 (5/1/2002)-CMS with the exception of "Activity Two, <i>Verifying Performance Improvement Project Study Findings</i> " (optional activity not mandated by CMS or The Division). Submission of findings to include an assessment about the extent to which the State should accept the findings of the HMO's Performance Improvement Project as valid and reliable, all worksheets included in Attachment B of the protocol, a list of 30 enrollees that met the numerator criteria for Diabetes Care for Adults, and submission of the list of selected validation documents and processes.	1	Upon Completion and Acceptance by the Division	
Validation of Performance Measures using CMS protocols and worksheets. (42 CFR Section 438.358(b)(2)-	Completion of "Validating Performance Measures" protocol, Version 1.0 (5/1/2002)-CMS to include review of the data management processes of the HMO, evaluation of	1	Upon Completion and Acceptance by the Division	

Validation of MCO or PIHP performance measures reported (as required by the State) or MCO or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in 438.240(b)(2)	algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the State, and verification of a sample of the State-specified performance measures to confirm that the reported results are based on accurate source information. Completion of pre-onsite, HMO onsite, and post site visit activities and worksheets per the protocol. Submission of all worksheets in Attachments I-XV of the protocol to the Division.			
EQR Results (42 CFR Section 438.364(a)(1)-(c)) External quality review results- (a) Information that must be produced.	<p>A detailed technical report that describes the manner in which the data from all activities conducted in accordance with Section 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timelines, and access to the care furnished by the HMO to include the following for each activity:</p> <ul style="list-style-type: none"> <li>Objectives (define objectives of the report)</li> <li>Technical methods of data collection and analysis.</li> <li>Description of data obtained.</li> <li>Conclusions drawn from the data.</li> <li>An assessment of the HMO's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients.</li> <li>Recommendations for improving the quality of health care services furnished by the HMO</li> </ul>	1	Upon Completion and Acceptance by the Division	
Total Payments				

IN WITNESS WHEREOF, the parties hereto have executed this Amendment in duplicate originals, with one original being retained by each party.

Medical Review of North Carolina, Inc.

By: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

NORTH CAROLINA DEPARTMENT  
OF HEALTH AND HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE

By: \_\_\_\_\_  
Gary Fuquay, Director

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**ATTACHMENT II**

**EXAMPLES OF PLAN MOBILIZATION AND**  
**QUARTERLY QM MEETINGS AGENDA AND**  
**MINUTES**

## **ACCESS II/HMO Plan Mobilization Meeting**

Tuesday—December 14, 2004

1:15 p.m.

Mecklenburg Co. DSS

# **Meeting Agenda**

## ***I. Welcome and Introductions.***

Please sign the attendance sheet in circulation.

## ***II. DMA Update.***

1. Current managed care enrollment figures for Meck. Co.
2. Current number of Managed Care Exemptions in Meck. Co.
3. Medicaid Management Information System (MMIS).
4. Julia McCollum phasing out of Mecklenburg County Responsibilities effective 1/1/05.
5. LaRhonda Cain will be Mecklenburg County contact for DMA-Managed Care issues.

## ***III. Old Business.***

1. Mislinks (to include pregnant women).
2. Review the process re: HMO (newborn) Transmittals.
3. CCPGM-CMC Policies re: member co-payments, scheduling.
4. Documentation in medical records regarding mislinks. (CCPGM)

## ***IV. New Business.***

1. CA I provider renewal applications.
2. Effective 1/1/05, DMA Provider Services will process all Medicaid Provider Enrollment applications. 919-855-4050 (Previously done by BC/BS.)

## ***V. Open Discussion.***

Schedule next meeting and any other topics.

## ***VI. Adjourn Meeting.***

## **Access II/HMO Plan Mobilization Meeting – Minutes**

Tuesday, Dec. 14, 2004

1:15 pm

Facilitator: Julia McCollum – DMA, Managed Care Consultant

Location: Mecklenburg County Dept. of Social Services

*Attendees* – Julia McCollum; LaRhonda Cain; Dawn Conoly; Kim Moore; Sue Tucker; Sandy Williams; Marizetta Moore; Cheryl Harris; Carolyn Allison; Alberto Vigo; Marimartha Matthews; Karen Brown; Diane Gonzalez; Kristin Wade; Vanessa McCants (via telephone); and Kevita Ratan (via telephone).

### *Opening & Introductions*

- Agenda distributed.
- Each attendee introduced him/herself and affiliated organization and agency.
- Sign-In Sheet distributed.

### *DMA Updates Given by Julia McCollum & LaRhonda Cain*

- Managed care enrollment figures (Dec. '04) for Mecklenburg County were distributed.
- Exemption report (as of Nov. 23, 2004) for Mecklenburg County was distributed and discussed. Amount of recipients with Exempt Code 30 were high and over 1600 were left from previous month. Vanessa/PCG was asked about the high exempt numbers.
- New MMIS scheduled for July 2006 and currently in design phase. Will provide direct access to reports on web and financials. Medicaid bulletins will provide an ACS link and ACS updates.
- Announcement made that Julia McCollum phasing out of Mecklenburg County responsibilities effective 1/1/05, and LaRhonda Cain will be Mecklenburg County contact for DMA/Managed Care issues.

### *Old Business*

- Mislinked pregnant women were presented as an issue. During the enrollment process, or while pending, these recipients visit CMC providers. In the following months, they are linked with SouthCare; however Carolina Access submit lists to DMA to have recipients removed from SouthCare. PCG, SouthCare, CMC, & DSS agreed to produce a work plan and resolution. Debbie Espin will coordinate conversations/meetings between entities for this issue.

- Per Diane Gonzales, no recent incidents with HMO (newborn) transmittals. Case considered closed. Question asked if DMA still receives newborn transmittals, and who retro-enrolls them? To be clarified at next PMM meeting.

Access II/HMO PMM – Dec. 14, 2004  
Minutes cont'd.

- CCPGM – CMC policy re: co-payments and scheduling no longer an open issue. Questions have been answered.
- Documentation in medical records for mislinks was addressed by Alberto Vigo on behalf of CCPGM. A confidential log of patient's visits are kept. Recipients asked to sign a statement authorizing change of PCP. Logs are sent to CCPGM – CMC effective 1/1/05. A copy of the log to be used was shown to the group. Alberto confirmed the logs and documentation to be HIPAA compliant.

#### *New Business*

- Julia McCollum explained why renewed Carolina Access Provider Application are needed, and process for which DMA is handling the applications. DMA/Program Ops assisting Provider Services with reviewing applications and contracts. Processing delays due to issues/discrepancies with apps received. P.O. anticipates the apps to be caught up in Jan. or Feb. '05.
- Julia McCollum announced that DMA/Provider Services will process all Medicaid Provider Enrollment applications effective 1/1/05. Previously handled by BCBS. Contact Provider Services for related questions at (919) 855-4050. Question raised about DMA turnaround time for processing provider enrollment applications and if retro-effective dates will be given. To be clarified at next PMM.
- 2005 PMM schedule as follows: March 15; June 21; Sept. 20; and Dec. 13. Location remains to be Mecklenburg Co. DSS.



**HMO Quarterly QM Minutes  
For June 28, 2004 Conference Call  
1pm-3pm**

**Attendees:**

**Esther Watson, Wellpath**

**Sue Steffes, MRNC**

**Cheryl Harris, Wellpath**

**Terri Bruner, DMA**

**Marilyn Domantay-Diaz, IPA**

**Deborah Bowen, DMA**

<b>Item</b>	<b>Discussion</b>	<b>Action</b>
<b>Review and approval of last meeting minutes</b>	<b>Kathy Dempsey's name was added to attendees and Cheryl Harris' name was deleted.</b>	<b>None further. Attendees sent corrected minutes before meeting.</b>
<b>Mecklenburg Update</b>	<b>Julia and Darryl were absent from the meeting.</b>	<b>Terri will have Julia email attendees with the update.</b>
<b>Audit Issues, Questions</b>	<b>Interviews with QM staff if necessary 7/21-24</b>	<b>Terri and/or Anne will participate in interviews if necessary.</b>
<b>External Quality Review</b>	<b>Sue Steffes discussed timeline for EQR activities and stated that timeline will depend on when desk review materials are received from plan. Esther stated that Aug. 10-11 would not be feasible for Wellpath as the company is moving those days. Timeline to begin is projected to be the last week of August. Sue explained that 30 medical records (numerator generated from HEDIS Adult Diabetes measure) would be reviewed. Marilyn stated that there were only 24 adult diabetes charts meeting the criteria. Esther requested a month's notice from</b>	<b>Terri will work with Sue regarding Southcare notifications and conduct of the review.</b>

	<p><b>MRNC for materials needed. Esther also stated that the CATALYST computer program was proprietary to SAS and programming language could not be shared with MRNC. Sue will clarify with MRNC IT staff as to what they will need to evaluate the IS system of Southcare. Esther also requested written requests for materials from MRNC before materials are sent out and Sue and Terri agreed that written notifications will be sent. Sue also updated the group on the progress of the CSHCN study, stating that approximately 1/2 of the chart abstractions have been completed.</b></p>	
<b>RFP Process for EQR</b>	<p><b>Terri stated that the RFP has been written and is now in Contracts Section for approval. Will notify all when the RFP is published and keep group updated.</b></p>	<p><b>Terri to keep group informed of progress.</b></p>
<b>Performance Improvement Project Update</b>	<p><b>Marilyn stated that she would report status next meeting.</b></p>	<p><b>Marilyn will be added to agenda next meeting.</b></p>